Interventionist Evaluation of *All Women Count!*

WISEWOMAN

A Cardiovascular Disease Screening and Health Promotion Program for Low-income Women in South Dakota

A Report to the South Dakota Department of Health

written by

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Abstract

Background

This project was the second component of a process evaluation of a South Dakota (SD) Department of Health program funded by the Centers for Disease Control and Prevention. *"All Women Count!"* (AWC) is the state's breast and cervical cancer screening program, which includes a specific project called WISEWOMAN. Through WISEWOMAN, qualifying low-income and uninsured women aged 40-64 years are screened for cardiovascular and diabetes risk factors, referred and offered four physical activity and healthy eating counseling sessions with trained health professionals.

Purpose

The purposes of this component of the evaluation project were to examine the AWC interventionists: a) perceptions of program orientation materials and resources, b) perceived ability to counsel about healthy eating and physical activity behavior change, c) counseling roles and behavioral skill strategies employed, d) time spent on diet, activity, smoking, alcohol use and other counseling topics, e) personal attitudes, practices and beliefs about healthy eating and physical activity, f) perceptions of participant recruitment and referral/follow-up strategies, and g) their beliefs about the overall value of the WISEWOMAN component of the AWC program.

Method

This evaluation project used a survey research method. The four-page paper and pencil survey was modified for this project from a similar survey used by the North Carolina WISEWOMAN evaluation team. The survey was completed by AWC interventionists who attended an annual training in the summer of 2004. Interventionists who were not present were mailed the surveys. There were 34 of 38 surveys returned with usable data, for an 89% response.

Results

Most of the interventionists had worked with the WISEWOMAN component of the AWC program for six months or longer. Interventionists cited the AWC program orientation components as useful, but had the most difficulty in perceiving the value of the tobacco and cholesterol algorithms. The behavioral assessment tools for activity and healthy eating were perceived as useful although the tobacco assessment and referral tool was not perceived as favorably. Average counseling time per session was mainly spent on healthy eating (38 minutes) and physical activity (23 minutes). Interventionists agreed or strongly agreed that they were prepared for and successful at counseling women for improved eating and activity. Counseling strategies used the most were setting short-term goals and discussing obstacles to behavior change. More than 70% of interventionists practiced regular healthy eating and activity themselves. Recruitment strategies viewed as the most successful were direct invitation from a person at a health clinic, posters at health facilities and word of mouth. Referral to the participants own health provider for treatment or for physical activity permission was perceived as the most favorable referral mechanism (76%). The greatest challenges to WISEWOMAN implementation were obtaining medications for participants, recruiting participants and participant attendance at the follow-up sessions. The greatest barriers to program participation were the number of visits and lack of concern about health issues on the

part of the participants. More than 50% of the interventionists perceived the WISEWOMAN program as very valuable. Very few (10.5%) of the interventionists viewed the program as having not much value.

Interventionists suggested modifications to the intervention materials including simple ways to encourage walking and other common activities (including seasonal activities), use of simple pictures of activities, activity guidance for musculoskeletal problems, and easy to use step counters or exercise videos as incentives. Interventionists suggested the use of food models for portion control and simplification of printed materials that also include guidance for carbohydrate counting, eating out, menu planning, and materials about beverage intake assessment and strategies. Interventionists were not sure that referral to the South Dakota telephone quit-line was an effective way to address cessation of tobacco use.

Conclusions and Recommendations

The 2004 South Dakota WISEWOMAN participant evaluation and the 2004 interventionist evaluation had both similarities and differences. Both the participants and the interventionists perceived the value of the program and the program materials as very good. Barriers to participation were different. Participants viewed time as the most important barrier to participation while interventionists perceived the number of visits as most difficult. Interventionists employed creative strategies to help women access the counseling sessions. These strategies included meeting in alternative places, phone counseling and combining visits. The referral process was viewed as a barrier to program implementation by interventionists. This concern was also cited by participant respondents in their evaluation. Stronger marketing of the program and communication about the program at the health facility and in the community, including places where low-income women are employed were cited as important to program success. Better integration with health facilities and communication is needed. Interventionists want simpler activity sheets that promote usual activities like walking. There is a need to explore the effectiveness of the SD telephone quit-line for cessation of tobacco use. Interventionists desire some assistance with addressing unfolding mental health issues like stress, depression and anxiety. The WISEWOMAN program in SD is perceived favorably by the interventionists who deliver the counseling interventions.

Acknowledgements

Support for this project was provided by the South Dakota Department of Health. The All Women Count! WISEWOMAN project coordinator, Patty Lihs, BS and the project director, Norma Schmidt, MA provided background information and feedback throughout the project period. The North Carolina (NC) WISEWOMAN Project Coordinator, Beverly Garcia provided copies of materials and resources used by the NC project site. The project assistant for this research was Courtney A. Thompson, BS, a prenursing student at South Dakota State University.

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Interventionist Evaluation of *All Women Count!* WISEWOMAN

A Cardiovascular Disease Screening and Health Promotion Program

for Low-income Women in South Dakota

In 1995, the CDC initiated a new program called WISEWOMAN, an acronym referring to Well-Integrated Screening and Evaluation for Women Across the Nation (CDC, 2003). WISEWOMAN is an extension of an existing nationwide program for early detection of breast and cervical cancer among low-income women. The South Dakota WISEWOMAN project is implemented as part of the SD breast and cervical cancer program called "All Women Count!". Participants in All Women Count! are also income-eligible for WISEWOMAN. Screening for qualifying women aged 40-64 years began in 2001. Screening services include blood cholesterol, blood pressure and blood sugar. Nutrition and physical activity interventions are delivered in four counseling sessions and are derived from *A New Leaf-Choices for Healthy Living* (Keyserling et al., 1999) and *Active Living Every Day* (Blair et al., 2001). A participant evaluation of the SD AWC project was completed in 2004, indicating very favorable findings for program satisfaction and improved eating and physical activity (Fahrenwald, 2004). What is unknown is how the interventionists who deliver the AWC interventions for healthy eating and activity perceive the program.

Purpose

The purposes of this component of the evaluation project were to examine the AWC interventionists: a) perceptions of program orientation materials and resources, b) perceived ability to counsel about healthy eating and physical activity behavior change, c) counseling roles and behavioral skill strategies employed, d) time spent on diet, activity, smoking, alcohol use and other counseling topics, e) personal attitudes, practices and beliefs about healthy eating and physical activity, f) perceptions of

participant recruitment and referral/follow-up strategies, and g) their beliefs about the overall value of the WISEWOMAN component of the AWC program.

Design and Method

This descriptive evaluation research used a four-page paper and pencil survey of all WISEWOMAN interventionists working with the SD program in the summer of 2004. Institutional Review Board approval for research involving human subjects was obtained from South Dakota State University (SDSU). An informational cover letter introduced the study and informed the interventionists of their rights as participants (Appendix A). Informed consent was implied by returning the completed survey. A participant identification number was included on the survey and both for tracking purposes.

Survey Tool

The interventionist evaluation tool was designed for this study. Instrument development was done in collaboration with the SDDOH WISEWOMAN project director and project coordinator and was derived in part from materials developed by the North Carolina (NC)WISEWOMAN pilot project (NC WISEWOMAN, 2000). The 4-page survey included 114 questions with multiple response formats designed to capture: a) the perceptions of the WISEWOMAN program among the interventionists, b) the perceptions and application of the counseling role, and c) other program implementation issues such as recruitment, referral, and resources. A sample copy of the survey tool is included as Appendix B.

Statistical Analysis

All data were analyzed using the *Statistical Package for the Social Sciences (SPSS) Version 11.0*® (2001). Frequency counts and descriptive statistics were used to describe the sample and to answer the research questions.

Results

The following subsections include a description of the sample. A detailed analysis of each of the study purposes is provided.

Interventionist Characteristics

Surveys were completed by 34 of 38 (89%) AWC interventionists in 2004. Figure 1 displays the length of time working with the AWC program as an interventionist. Most of the interventionists had worked with the WISEWOMAN component of the AWC program for six months or longer. The interventionists varied widely in the number of women counseled (range = 0-75). Figure 2 displays the number of AWC participants counseled. Nearly 50% of the interventionists had counseled more than 30 women total.

Figure 1

Time working with AWC! program (N=34)

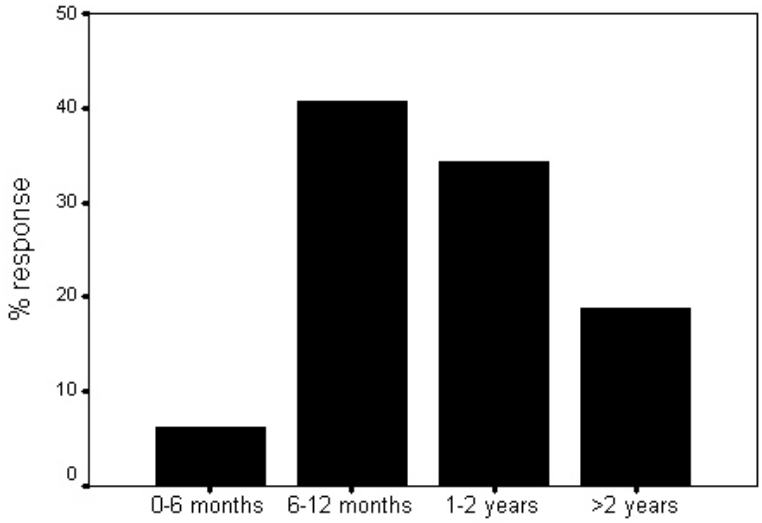
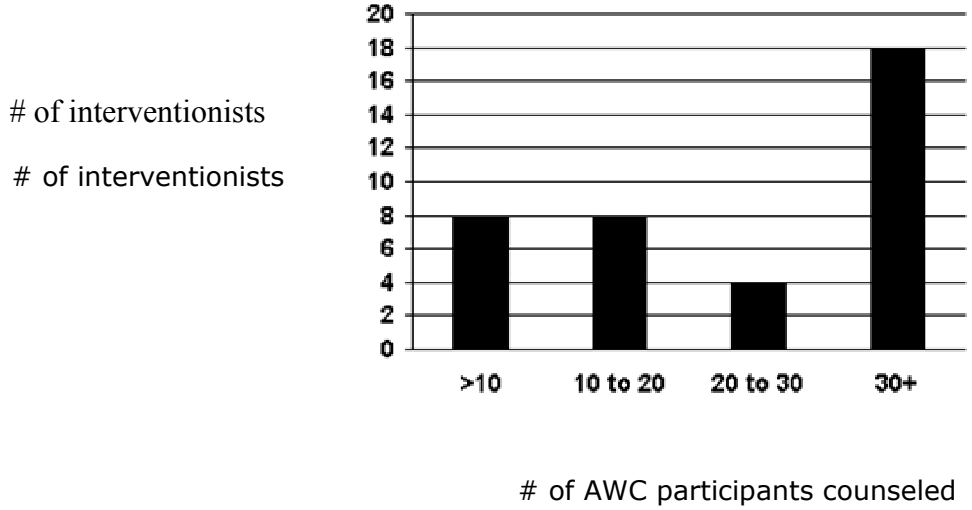


Figure 2

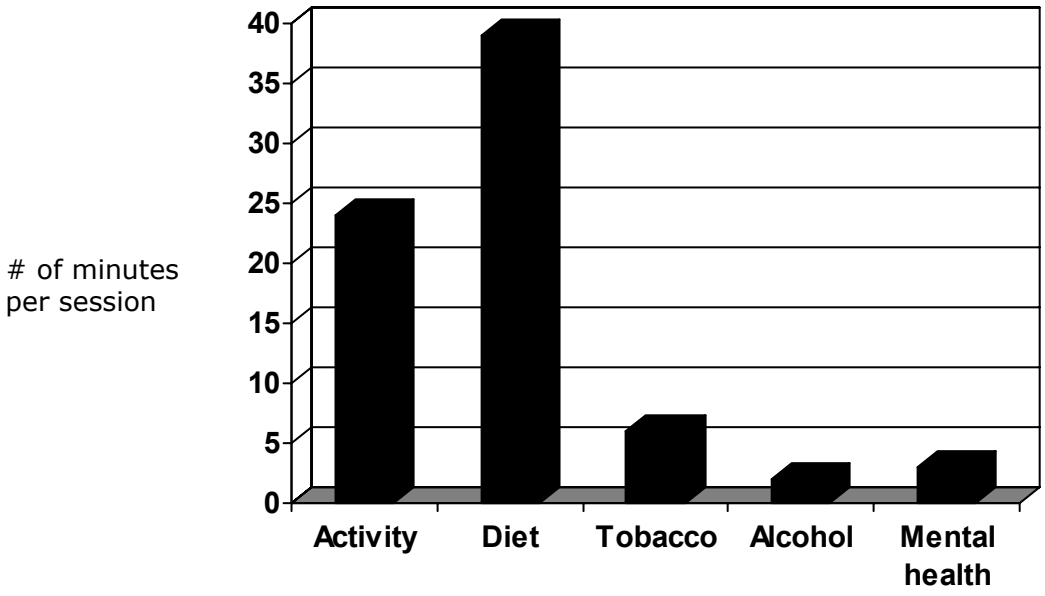
Number of AWC Participants Counseled by Interventionists



Interventionists indicated the number of minutes spent counseling participants on different health behaviors. Figure 3 displays the time spent on counseling for healthy eating, physical activity, tobacco use, alcohol use and mental health issues. Counseling time per session was mainly spent on healthy eating (38 minutes) and physical activity (23 minutes).

Participants are referred to the SD telephone quit-line for tobacco use, therefore reflecting a reduced amount of time on this topic. Mental health issues were a minimal part of counseling sessions. However, six interventionists did write comments indicating a need for skills in stress management, identifying depression and managing anxiety.

Figure 3. Time Spent on Counseling Types per Visit



Perceptions of the WISEWOMAN Program

Interventionists were asked about their perceptions of program orientation materials and their satisfaction with the behavioral assessment tools. Counseling roles and activities employed were described. Each of these components of the evaluation is described next.

Orientation to the Program

Interventionists rated the perceived usefulness of the intervention materials for healthy eating (*New Leaf*) and physical activity (*Active Living*). Algorithms for referral and education of women who are tobacco users or for treatment protocols for cholesterol, glucose and blood pressure were also rated. Table 1 presents the results of these assessments. The intervention materials for both healthy eating and activity were perceived as useful by 70% of interventionists. Algorithms for tobacco and cholesterol were not perceived as favorably. The glucose and blood pressure algorithms were more

useful to the interventionists (72% - 79%). Overall, the program training manual received a very favorable rating for usability (85%).

Table 1

Perceived Usefulness of Program Orientation Components

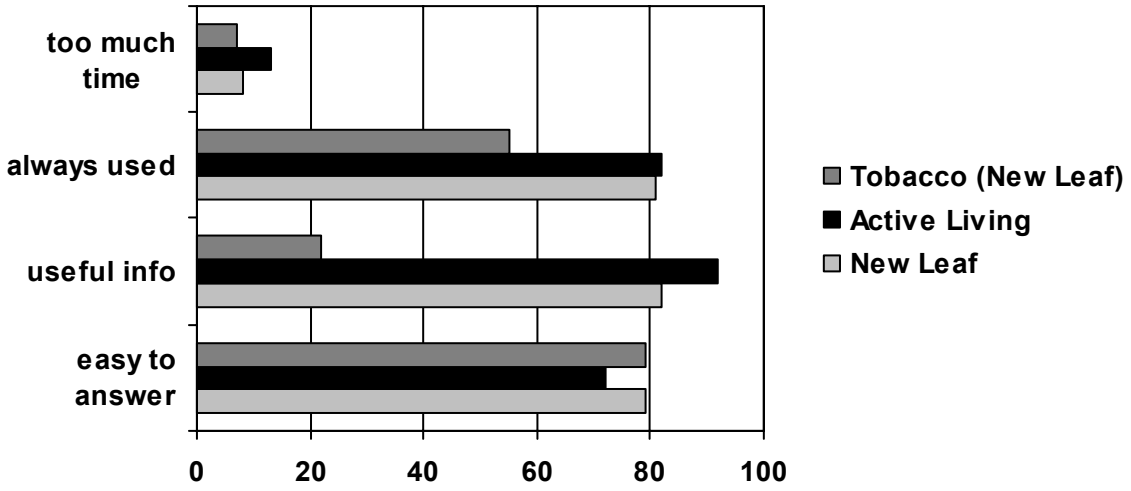
Orientation Component	Useful	Not useful
"New Leaf"	70%	30%
"Active Living"	72%	28%
Tobacco algorithm	49%	45%
Cholesterol algorithms	58%	42%
Glucose algorithm	72%	28%
Blood pressure algorithm	79%	21%
Program manual	85%	15%

Satisfaction with the Behavioral Assessment Tools

Interventions indicated their overall satisfaction with the tools used to assess participant diet, activity and tobacco product use. Questions queried respondents about whether the tools took too much time and whether they were simple to use. Figure 4 provides a summary of the responses. The behavioral assessment tools for activity (Active Living) and healthy eating (New Leaf) were perceived as useful although the tobacco assessment and referral tool was not perceived as favorably. Interventionists agreed that these tools took very little time and provided helpful information.

Figure 4

Perceptions of Behavioral Assessment Tools



Counseling Role and Activities

Interventionists were asked to indicate how strongly they agreed or disagreed with various components of the counseling role for both healthy eating and activity. Results are displayed in Table 2. Interventionists agreed that counseling for physical activity and healthy eating were appropriate for their role and that they had the resources available to counsel effectively. Interventions were less in agreement that they were successful in helping women to achieve long-term health behavior change. Time as a barrier to counseling was a neutral factor for the interventionists who neither agreed nor disagreed about this issue.

Counseling activities, including roles employed and behavioral skills used by the interventionists, are displayed in Table 3. Interventionists almost always used their time to set health behavior change goals. They also almost always employed behavioral skill development techniques by addressing potential obstacles to health behavior change. Interventionists were careful to correctly portray the health benefits of moderate physical activity and to consider musculoskeletal conditions that may limit physical activity for women.

Table 2

Perceptions of Health Counseling

Item	Mean (±*SD*)	1 Strongly Disagree	2	3	4	5	6 Strongly Agree
I am generally successful in helping women to make lasting dietary changes.	3.9 (0.9)	**********					
I have the educational resources available to offer an effective dietary improvement program.	4.8 (1.3)	**********	**********	**********			
Time is a major barrier to nutrition and physical activity counseling.	3.7 (1.5)	**********	**********				
I feel well prepared to help women improve eating habits.	4.5 (1.3)	**********	**********	**********			
I see nutrition counseling as an essential part of my role.	5.0 (1.3)	**********	**********	**********	**********	**********	**********
I am generally successful in helping women to increase and maintain physical activity.	3.8 (0.8)	**********	**********				
I have the educational resources available to offer an effective physical activity program.	4.4 (1.3)	**********	**********	**********			
I feel well prepared to help participants increase their level of physical activity.	4.3 (1.2)	**********	**********	**********			
I see physical activity counseling as an essential part of my role.	5.0 (1.2)	**********	**********	**********	**********	**********	**********

Table 3

Health Counseling Activities

Counseling Activity	Never - Rarely	Often-Always
Set short term diet change goals	9%	91%
Set short term activity goals	7%	93%
Advised to limit starchy foods	13%	87%
Discussed attitudes about change	18%	82%
Discussed obstacles to change	9%	91%
Advised, "if you don't sweat it is not worth it".	89%	11%
Discussed osteoporosis	21%	79%

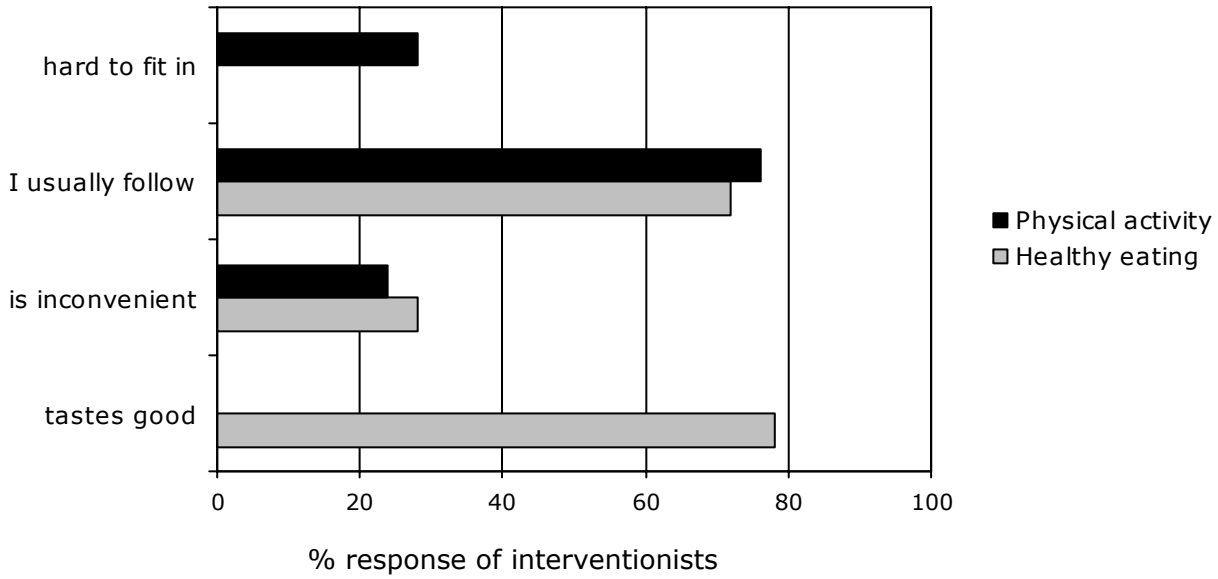
After the counseling sessions interventionists had essentially no contact with WISEWOMAN participants. However, there was email, in-person, or phone contact once or twice a year that took place between some interventionists and WISEWOMAN participants.

Interventionist Health Habits and Beliefs

Interventionists were queried about their attitudes, beliefs and health practices related to physical activity and healthy eating behaviors. More than 70% of the interventionists indicated that they usually participate in regular activity and eat a healthy diet. There were some perceptions of activity as both difficult to fit into the day and inconvenient among more than 20% of the interventionists.

Figure 5

Interventionist Health Habits and Beliefs



Program Implementation: Recruitment, Challenges and Barriers

Interventionists rated the success of participant recruitment strategies (Table 4). Recruitment strategies viewed as the most successful were direct invitation from a person at a health clinic, posters at health facilities and word of mouth. Interventionists were not highly involved in program recruitment as indicated by the following written comments.

"I just get the referral. I don't recruit."

"The clinic needs to promote the program more."

"Get the word out more."

Recruitment of WISEWOMAN participants is not necessarily a perceived role of the interventionists but they do favor integration of recruitment messages within health facilities.

Table 4

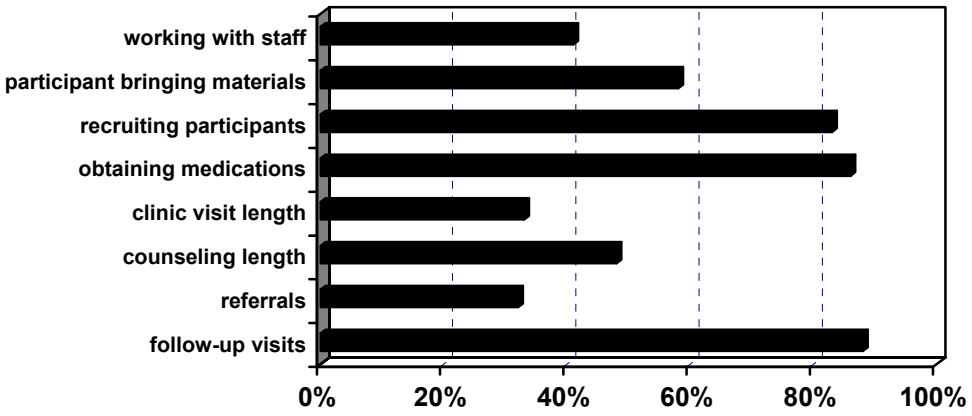
Perceived Success of WISEWOMAN Recruitment Strategies

Perceived success of recruitment strategies	Mean (±*SD*)	1 Not at all Successful	2	3	4	5	6 Very Successful
Recruitment from existing AWC! screening sites	3.5 (1.2)	**********					
Invitation during other clinic visits	4.1 (1.0)	**********					
Invitation at time of scheduling appointment	3.4 (1.2)	**********					
Verbal announcement at health facility	3.3 (1.2)	**********					
Poster at health facility	4.3 (1.0)	**********					
Community Outreach (newspaper, flyers, etc.)	3.7 (0.9)	**********					
Community events (health fairs, etc.)	3.7 (1.2)	**********					
Other – Word of mouth (n=7)	4.3 (1.1)	**********					

Potential challenges to program implementation were rated as problematic or not problematic by the participants (Figure 6). The number of follow-up visits, recruiting participants and obtaining participant medications were perceived as the most problematic implementation issues. Approximately one-half of the interventionists agreed that participants did not always bring their intervention materials to follow-up visits and that the length of visits was sometimes a barrier to program implementation. About 40% of the interventionists indicated that working with clinic staff made program implementation problematic at times.

Figure 6

Challenges to Program Implementation



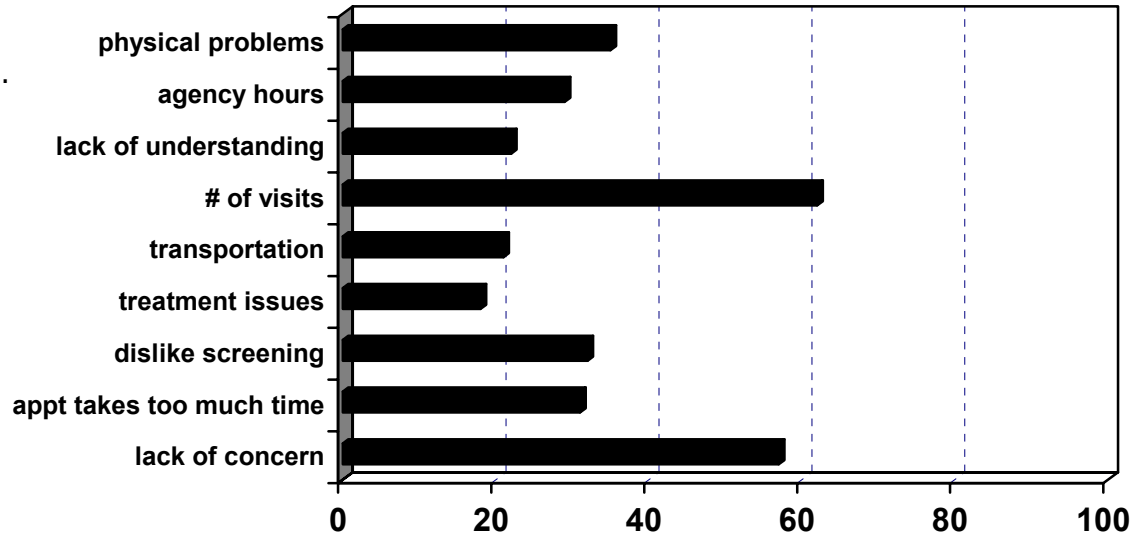
Interventionists rated what they perceived as the most important barriers to program participation (Figure 7). The number of required counseling visits and lack of concern on the part of the participants were the top barriers. Other barriers that were cited by more than 20% of the interventionists were physical health problems, agency hours, lack of participant understanding, dislike of health screenings and time.

Interventionists indicated that the success of participant referral for high blood pressure, high cholesterol, high glucose or permission to participate in physical activity was most successful when the participant had a personal health care provider. Problems with the referral mechanisms were cited. Interventionists indicated that participants were not always aware of their referral to the interventionist. Participants were also not always aware of their elevated screening tests. Participants were sometimes referred for a stress test for activity permission but this test is not covered by the program. Interventionists suggested that dedicated clerical and staff support and the health clinic could help to improve recruitment and referral problems. Better communication about the breast and cervical cancer component of the program combined with the

cardiovascular component is needed. Interventionists also indicated that they receive too much information about the participant at the time of referral.

Figure 7

Perceived Barriers to Program Participation



Suggested Modifications of the WISEWOMAN Interventions

Interventionists were asked for their input into the actual intervention materials. There was strong agreement that the activity sheets needed to encourage simple exercises like walking and seasonal alternatives. Interventionists also suggested that the program incentives could include a simple and easy to use step counter or pedometer and a basic exercise video for in-home use. Orthopedic and other joint problems make physical activity difficult for may SD AWC participants (Fahrenwald, 2004) and the interventionists echoed this issue with their request for simple exercise guidance for women experiencing these conditions.

Interventionists also suggested changes to the healthy eating intervention materials. Food models were requested to assist with explanation of portion control. Interventionists are often asked for simple guidance with eating out, menu planning and

carbohydrate counting. In addition, women requested that the intervention materials offer better help with beverage intake assessment and intervention. The overall theme of the interventionist comments for activity and healthy eating interventions was to simplify the materials.

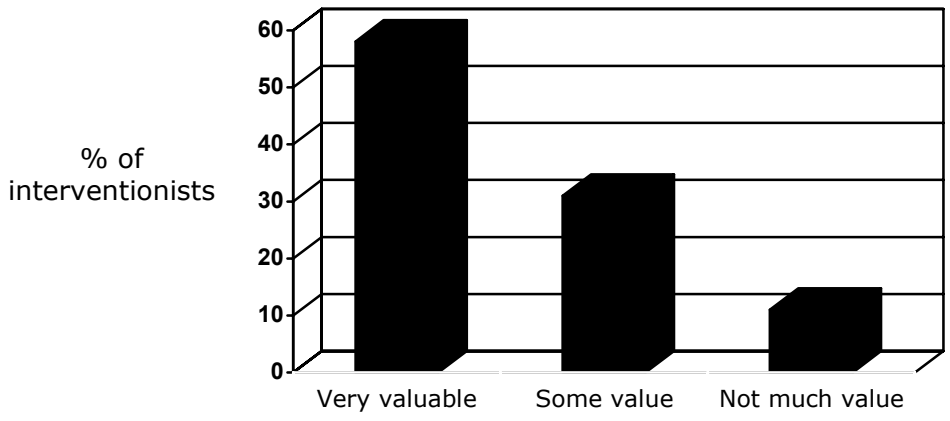
Interventionists also requested more assistance with assessment and intervention for tobacco use. Referral to the SD telephone quit-line is not perceived as the best approach when some women lack telephone access.

Overall Perceived Value of the WISEWOMAN Program

The interventionists were asked to rate the overall value of the WISEWOMAN component of the AWC program. Nearly 90% of the interventionists rated the program as somewhat to very valuable (Figure 8). Further analysis indicated that five of the interventionists who had counseled less than 10 participants perceived the program as the least valuable.

Figure 8

Perceived Overall Value of the WISEWOMAN Program



Limitations

The interventionists who participated in this evaluation varied greatly in the number of AWC clients counseled for healthy eating and activity. Because of the small

sample size, it was not possible to stratify the analysis by length of time working with the program or number of participants counseled.

Conclusions and Recommendations

Supplementing the existing All Women Count! cancer screening program for low-income SD women with cardiovascular disease risk factor assessment was perceived as satisfactory by the interventionists who offer the lifestyle intervention counseling. The 2004 South Dakota WISEWOMAN participant evaluation and the 2004 interventionist evaluation had both similarities and differences. Both the participants and the interventionists perceived the value of the program and the program materials as very good. Barriers to participation were different. Participants viewed time as the biggest barrier to participation while interventionists perceived the number of visits as most difficult. Interventionists employed creative strategies to help women to access the counseling sessions. These strategies included meeting in alternative places, phone counseling and combining visits. The referral process was viewed as a barrier to program implementation by interventionists. This concern was also cited by participant respondents in their evaluation. Stronger marketing of the program and communication about the program at the health facility and in the community, including places where low-income women are employed were cited as important to program success. Better integration with health facilities and communication is needed.

Interventionists want simpler activity sheets that promote usual activities like walking. Overall, there is a need to simplify and restructure some of the healthy eating and activity intervention materials. Suggestions for more meaningful incentives included easy to use step counters and an exercise video. There is a need to explore the effectiveness of the SD telephone quit-line for cessation of tobacco use. Interventionists desire some assistance with addressing unfolding mental health issues like stress, depression and anxiety. The WISEWOMAN program in SD is perceived favorably by the interventionists who deliver the counseling interventions.

References

Blair, S. N., Dunn, A. L., Marcus, B. H., Carpenter, R., Jaret, P. (2001). *Active Living Every Day.* Champaign, IL: Human Kinetics.

Centers for Disease Control and Prevention (2003). *WISEWOMAN: Improving the Health of Uninsured Women*. Atlanta: Author.

Fahrenwald, N. L. (2004). *Process Evaluation of All Women Count! WISEWOMAN A Cardiovascular Disease Screening and Health Promotion Program for Low-income Women in South Dakota*. Brookings, SD: South Dakota State University.

Keyserling, T., Ammerman, A., Atwood, J., Hosking, J., Krasny, J., Zayed, H., & Worthy, B. (1999). A cholesterol intervention program for public health nurses in the rural southeast: description of the intervention, study design, and baseline results. *Public Health Nursing, 16*, 156-67.

North Carolina WISEWOMAN (2000). *WISEWOMAN Program Materials and Resources*. Chapel Hill, NC: Prevention Research Centers.

Appendix A

Informed Consent Letter

All Women Count!
South Dakota Project
Interventionist Evaluation

June, 2004

Dear All Women Count Interventionist:

We want to know how the All Women Count project is working.

You are asked to be a part of this All Women Count research study. The enclosed survey asks questions about the All Women Count program. Your time is important so we kept the form as brief as we could. The survey will take about 60 minutes of your time. Your participation in this project is voluntary.

There are no known risks linked to this study. The surveys questions ask for your thoughts and ideas about the All Women Count program. Results from this study will provide the SD Department of Health with knowledge about how the All Women Count program is working.

Your responses are confidential. The findings from the study may be published in scientific journals or presented at scientific meetings, but your identity will be kept strictly secret. You can choose to be a part of this study, or you can choose not to be a part of this study. If you choose not to be a part of the study you will not lose any All Women Count program benefits or services.

Please assist us in our research. Your consent is implied by completing the survey***.*** ***Please keep this letter for your information.*** You have the right to not be a part of this study or to withdraw at any time. Your rights as a research participant have been explained to you. If you have any additional questions concerning your rights, you may contact the South Dakota State University Institutional Review Board (IRB) chairperson, Debra Spear, telephone 605-688-6578, email: Debra_Spear@sdstate.edu.

If you have any questions, now or later, you may contact me at the number below. Thank you very much for your time.

Sincerely,

Nancy Fahrenwald, PhD, RN
Project Director: All Women Count Evaluation
South Dakota State University, College of Nursing
Box 2275
Brookings, SD 57007
Enclosures

Appendix B

Interventionist Evaluation Tool

***All Women Count!* Interventionist Survey**

Do not put your name on the survey.

1 Please indicate the length of time that you have worked with the *All Women Count!* intervention program:

O 0-6 months	O 6-12 months	O 1-2 years	O >2 years

2 Estimate the number of *All Women Count!* participants you have counseled:_____

Considering your experience with *All Women Count!*, indicate your level of agreement or disagreement with items 3-11 regarding nutrition and physical activity counseling.

		Strongly Disagree					**Strongly Agree**
3	I am generally successful in helping participants make lasting dietary changes.	1	2	3	4	5	6
4	I have the educational resources available to offer an effective dietary improvement program to participants.	1	2	3	4	5	6
5	Time is a major limiting factor in offering nutrition and physical activity counseling.	1	2	3	4	5	6
6	I feel well prepared to help participants change their dietary habits.	1	2	3	4	5	6
7	I see nutrition counseling as an essential part of my role.	1	2	3	4	5	6
8	I am generally successful in helping participants to increase their level of physical activity and maintain it.	1	2	3	4	5	6
9	I have the educational resources available to offer an effective physical activity program to participants.	1	2	3	4	5	6
10	I feel well prepared to help participants increase their level of physical activity.	1	2	3	4	5	6
11	I see physical activity counseling as an essential part of my role.	1	2	3	4	5	6

When counseling *All Women Count!* participants over the last year, how often did you use the following strategies to help change their health behavior?

	Nutrition	**Never**					**Always**
12	Set short-term dietary behavior change goals with the participants.	1	2	3	4	5	6
13	Gave out written materials concerning a low fat diet.	1	2	3	4	5	6
14	Advised participants to limit starchy foods.	1	2	3	4	5	6
15	Discussed attitudes about lifestyle change with participants.	1	2	3	4	5	6
16	Discussed obstacles to lifestyle changes.	1	2	3	4	5	6
	Physical Activity	**Never**					**Always**
17	Set short-term goals with the participant to increase physical activity.	1	2	3	4	5	6
18	Gave out written materials concerning physical activity	1	2	3	4	5	6
19	Advised participants that if they don't sweat it's not worth it.	1	2	3	4	5	6
20	Counseled participants about osteoporosis (nutrition and/or physical activity).	1	2	3	4	5	6

21 **After a participant completes the *All Women Count!* nutrition and physical activity counseling program at your health facility, what usually happens?**

O	no further contact
O	phone or in-person follow-up once a year
O	phone or in-person follow-up twice a year
O	phone or in-person follow-up more than twice a year
O	other (specify)

When you counseled *All Women Count!* participants about lifestyle changes, about how long did you usually spend per visit?

22	Nutrition	_____	minutes
23	Physical Activity	_____	minutes
24	Smoking Cessation	_____	minutes
25	Alcohol Use	_____	minutes
26	Other (specify)		minutes

27 **On average, how many educational contacts (individual, group, or telephone) did you make with each *All Women Count!* participant? _____ contacts**

Indicate the extent to which you <u>personally</u> agree or disagree with the following:

	A diet low in saturated fat and cholesterol	**Strongly Disagree**					**Strongly Agree**
28	is often *inconvenient.*	1	2	3	4	5	6
29	generally tastes very good.	1	2	3	4	5	6
30	is something which I usually follow.	1	2	3	4	5	6
	Being physically active or exercising:	**Strongly Disagree**					**Strongly Agree**
31	Is often *inconvenient*.	1	2	3	4	5	6
32	Is hard to fit into my schedule.	1	2	3	4	5	6
33	Is currently a regular part of my life.	1	2	3	4	5	6

How useful were the following components of the program?

		<u>N/A</u>	**Not useful**				**Very**
34	Orientation training: *New Leaf* component	0	1	2	3	4	5	6
35	Orientation training: *Active Living* component	0	1	2	3	4	5	6
36	Algorithm training: Cholesterol	0	1	2	3	4	5	6
37	Algorithm training: Blood Pressure	0	1	2	3	4	5	6
38	Algorithm training: Glucose	0	1	2	3	4	5	6
39	Algorithm training: Tobacco Use	0	1	2	3	4	5	6
40	*All Women Count!* Program Screening Manual	0	1	2	3	4	5	6

How successful were the following strategies to recruit *All Women Count!* participants?

		Didn't use	**Not at all successful**				**Very successful**
41	Recruitment from existing breast and cervical cancer screening sites	0	1	2	3	4	5	6
42	Invitation during other clinic visits	0	1	2	3	4	5	6
43	Invitation at time of scheduling appointment	0	1	2	3	4	5	6
44	Verbal announcement at health facility	0	1	2	3	4	5	6
45	Poster announcement at health facility	0	1	2	3	4	5	6
46	Community Outreach (newspaper, flyers, etc.)	0	1	2	3	4	5	6

46	Community Events (health fairs, speaking to groups, etc.)	0	1	2	3	4	5	6
47	Other (specify)	0	1	2	3	4	5	6

How successful were the following approaches to physician referral for very high BP, cholesterol, blood sugar, or for permission to participate in a physical activity program?

		Didn't use	Not at all successful					Very successful
48	Referred participants to a physician in my health facility.	0	1	2	3	4	5	6
49	Participants saw their own doctor after receiving a referral.	0	1	2	3	4	5	6
50	Referred participants to a physician if participant did not have her own.	0	1	2	3	4	5	6
51	Referred participants to other agencies or clinics in community that were free or low cost.	0	1	2	3	4	5	6
52	Other (specify)	0	1	2	3	4	5	6

53 **If there were problems with the referral process, please explain problems and add your suggestions for improvements.**

Problem: Suggested Solution:

54 **Overall, how valuable was the *All Women Count!* program to your participants?**

O Very valuable, benefited many participants a great deal

O Some value, some participants benefited

O Not much value, few participants benefited. If you can, please tell us why:

In your opinion, what are the major barriers regarding women's participation in the *All Women Count!* program?

		Not a barrier	Somewhat of a barrier	Very much a barrier
55	Not concerned about lowering or maintaining cholesterol, blood pressure, or blood sugar.	1	2	3
56	Appointments take too much time.	1	2	3
57	Already being treated for cholesterol, blood pressure, or blood sugar.	1	2	3
58	Do not like health screenings.	1	2	3
59	Can't get to health facility during business hours.	1	2	3
60	Transportation problems.	1	2	3
61	Don't understand instructions or materials.	1	2	3
62	Too many visits required.	1	2	3
63	Physical limitations prohibit increased physical activity.	1	2	3
64	Changes in requirements for breast and cervical cancer screening eligibility (Medicare/Medicaid).	1	2	3
65	Other (specify)	1	2	3

For how many of the women that you worked with, did you provide counseling about:

		Most participants	Some participants	None
66	Nutrition	1	2	3
67	Physical activity	1	2	3
68	Smoking cessation	1	2	3

Please circle the number which best represents your opinion regarding the following segments of the *New Leaf* and *Active Living* intervention materials.

		N/A	Strongly Disagree					Strongly Agree
	Nutritional Risk Assessment (*New Leaf)*							
69	Was easy for participants to answer	0	1	2	3	4	5	6
70	Provided useful counseling information	0	1	2	3	4	5	6
71	Took too much time to administer	0	1	2	3	4	5	6
	Physical Activity Assessment *(Active Living)*							
72	Was easy for participants to answer	0	1	2	3	4	5	6
73	Provided useful counseling information	0	1	2	3	4	5	6
74	Took too much time to administer	0	1	2	3	4	5	6
	Smoking Cessation Assessment (*New Leaf)*							
75	Was easy for participants to answer	0	1	2	3	4	5	6
76	Provided useful counseling information	0	1	2	3	4	5	6
77	Took too much time to administer	0	1	2	3	4	5	6

Which of the following components of the *New Leaf* and *Active Living* interventions did you use most often in counseling *All Women Count!* participants?

		Not at all					Always
	Nutrition (*New Leaf Booklet - pink)*						
78	A: Intake Assessment: Nutrition (salmon sheet)	1	2	3	4	5	6
79	B: My Food Goals (pink book)	1	2	3	4	5	6
80	C: Healthy Eating (pink book)	1	2	3	4	5	6
81	D: Diabetes Prevention and Management (pink book)	1	2	3	4	5	6
82	E: Other Health Habits (pink book-supplement)	1	2	3	4	5	6
83	***New Leaf for South Dakota* recipe book**	1	2	3	4	5	6
	Physical Activity (*Active Living book)*						
84	Intake Assessment: Activity (salmon sheet)	1	2	3	4	5	6
85	Activity Sheet(s) (blue, green, yellow, red Activity Goal (signature sheet)	1	2	3	4	5	6
86	Activity Goal (signature sheet)	1	2	3	4	5	6
87	Barriers Assessment and Tip Sheet	1	2	3	4	5	6
88	Creative Rewards Sheet	1	2	3	4	5	6
89	Flexibility and Strength Exercises (Dynaband sheets)	1	2	3	4	5	6
	Smoking Cessation (*New Leaf)*						
90	Intake Assessment: Smoking (salmon sheet)	1	2	3	4	5	6
91	*South Dakota Quits* Information	1	2	3	4	5	6

92 **If some of the *New Leaf* materials were not used during the counseling, please indicate why and what you used instead:**

93 **If some of the *Active Living* materials were not used during the counseling, please indicate why and what you used instead:**

If you think some modifications would be helpful on the nutrition, physical activity, or smoking assessments or counseling materials, what would your suggestions be?

94 Nutrition

95 Physical Activity

96 Smoking Cessation

How often did you use these approaches to counseling with intervention materials?

		N/A	Never					Always
97	On-site counseling	0	1	2	3	4	5	6
98	Telephone counseling	0	1	2	3	4	5	6
99	Group counseling	0	1	2	3	4	5	6
100	Off-site counseling	0	1	2	3	4	5	6
101	Had participants complete nutrition assessment on their own	0	1	2	3	4	5	6
102	Had participants complete physical activity assessment on their own	0	1	2	3	4	5	6

103 **Participants were asked to bring intervention materials back for each counseling session. How often did this happen?**

O Never
O Sometimes
O Often
O Most of the time

104 **Overall, using the *New Leaf* notebook for counseling participants was:**

O Very helpful
O Somewhat helpful
O Not very helpful
O Not at all helpful. If you can, please tell us why:

105 **Overall, using the *Active Living* book for counseling for participants was:**

O Very helpful
O Somewhat helpful
O Not very helpful
O Not at all helpful. If you can, please tell us why:

What are the biggest challenges in continuing the All Women Count Program!?

		Big problem	Some problem	Not a problem
106	Implementing with existing numbers of staff	1	2	3
107	Referral to physician	1	2	3
108	Obtaining medications for women who cannot afford them	1	2	3
109	Length of clinic visit	1	2	3

110	Length of counseling visit	1	2	3
111	Getting participants back in for follow-up visits	1	2	3
112	Recruiting participants	1	2	3
113	Getting participants to bring materials to each visit	1	2	3
114	Other (Specify)	1	2	3